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Article

Rethinking Developmental Trauma Using the Child Attachment and Play Assessment

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ABSTRACT

Child abuse and neglect has a major impact on children's development and is a significant factor in a range of adult psychiatric disorders as wells as problems in relationships and social functioning. In the last two decades the effects of child maltreatment have been given a specific nosology in terms of a complex form of PTSD (CPTSD). Considerable progress has been made in validating questionnaires that screen for CPTSD and meet the criteria proposed by ICD11. Despite the basis of CPTSD in childhood, assessments have been biased towards adults and little use has been made of play based procedures for use with maltreated children. This paper argues for the use of the Child Attachment and Play Assessment (CAPA) as an additional assessment procedure. The CAPA uses the established narrative story stem procedure (NSSP) and codes for child attachment, unresolved loss and/or trauma, and observed somatic signs of trauma. Because it gives a direct window into the perception of the child it gives the therapist child specific information to help formulate an intervention plan most likely to help a particular child. The aim is not to supplant current assessments but enrich them. The term developmental trauma (DT) is preferred because the CAPA uses a psycho-social rather than medical model.

Reformulando el Trauma en el Desarrollo a Través del Child Attachment Play Assessment

Palabras clave:
Evaluación del apego y el juego infantil
Trauma del desarrollo
PTSD complejo
Apego
Modelo dinámico maduracional del apego

RESUMEN

El maltrato y la negligencia infantiles tienen un gran impacto en el desarrollo de los niños y son un factor significativo en una serie de trastornos psiquiátricos en la edad adulta, así como en problemas de relación y funcionamiento social. En las dos últimas décadas, los efectos del maltrato infantil han recibido una nosología específica en términos de una forma compleja de TEPT (TEPT Infantil). Se ha avanzado considerablemente en la validación de cuestionarios que detectan el TEPT y cumplen los criterios propuestos por la CIE11. A pesar de la base del TEPT en la infancia, las evaluaciones han estado sesgadas hacia los adultos y se ha hecho poco uso de procedimientos basados en el juego para su uso con niños maltratados. Este artículo propone el uso de la Evaluación del Apego y el Juego en el Niño (CAPA) como un procedimiento de evaluación adicional. La CAPA utiliza el procedimiento establecido de la narrativa de la historia (NSSP) y codifica el apego infantil, la pérdida no resuelta y/o el trauma, y los signos somáticos observados del trauma. Dado que ofrece una ventana directa a la percepción del niño, proporciona al terapeuta información específica sobre el niño para ayudar a formular un plan de intervención con más probabilidades de ayudar a un niño en particular. El objetivo no es suplantar las evaluaciones actuales, sino enriquecerlas. Se prefiere el término trauma del desarrollo (DT) porque el CAPA utiliza un modelo psicosocial en lugar de médico.

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The focus of this paper is the assessment and treatment of developmental trauma (DT) in children and adolescents. The main contributors to DT are child abuse and/or neglect and war; only the former is discussed here. Following a selective review of current diagnostic procedures, an alternative approach to assessment is offered in the form of the Child Attachment and Play Assessment (CAPA) using the established narrative stem story stems procedure (NSSP) (Emde et al., 2003). The aim is not to supplant current assessments but to show how the CAPA can enhance the understanding of a particular child's attachment and trauma and, crucially, help select the therapeutic intervention most likely to succeed. The final section has pointers for intervention and treatment together with a brief case study.

Child maltreatment has been typically categorised in terms of physical, sexual, emotional abuse and neglect. More recently, work on Adverse Childhood Experiences (ACEs) has widened the definition to include domestic violence, parental drug and alcohol abuse, parent separation and imprisonment (Maneiro et al., 2023). The global prevalence of maltreatment is high, for example the United Nations Children's Fund estimate 60% of children under 5 endure physical or psychological punishment at home (UNICEF, 2024). All forms of abuse can have an adverse impact on neurological development (Teicher & Samson, 2013); the effects persist into adulthood and are significant factor in the cause of many psychiatric diagnoses (Marques-Feixa et al., 2023). The consequences of childhood trauma are not restricted to individuals. When large populations of children are traumatised, there is an epigentic effect; for example environmental security allows more time for reproduction, girls reach the menarche later and the birth rate declines. Environmental dangers such as extreme poverty, child abuse and war activate the opposite (Belsky et al., 1991; Belsky, 2008).

Although the protection of children from abuse has long red in the social policy agendas of the USA, Antipodean and European countries, this has only recently been reflected in diagnostic criteria used by child welfare practitioners. In 1991 Terr's pioneering work on traumatised children made the useful distinction between the differences in "one off blows" and "long-standing or repeated ordeals" (Terr, 1991). This was followed by a concerted effort by van der Kolk arguing a new diagnosis was needed which he termed developmental trauma disorder (DTD) (van der Kolk, 2005). DTD was rejected by American Psychatric Association's (2013) Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5) but included in World Health Organization's (2019) International Statistical Classification of Diseases and Related Health Problems (11th ed., ICD-11) under the rubric of complex PTSD (CPTSD). In the process the focus on children was to some extent lost in attempts to formulate diagnostic criteria for CPTSD in adults (see Maercker, 2021, for review).

While there is a consensus that DTD/CPTSD originates in attachment relationships, the concept of a 'disorder' puts the focus of the problem onto the child; i.e. a disorder is something the child has. To emphasis the social origins of the problem, in this paper the term developmental trauma (DT) is preferred with reference to DTD or CPTSD when used by other writers.

Developmental Trauma

There are two main differences between DT and other forms of trauma. First, it entails abuse or neglect perpetrated by attachment figures. This can produce 'fear without solution,' inducing an approach-avoidance dilemma in that the very people who are supposed to protect the child (Parents) are also the source of harm. Second, it is multiple and chronic. Various types of abuse frequently occur together over long periods of development (Terr's "long-standing or repeated ordeals") and unlike PTSD it is usually difficult to identify a specific traumatic event that has caused the child's problems. To be classed as traumatic, threats or actual acts of harm to the self or self-substitutes, such as siblings, must be severe enough for the child to doubt their safety, psychological integrity and even physical survival.

ICD-11 Complex PTSD

For a diagnosis of Complex PTSD in adults the three core elements of PTSD have to be met. 1) Re-experiencing the traumatic event (e.g., flashbacks, intrusive memories or images, nightmares). This is more than a matter of reflecting on traumatic episodes but involves acute mental and physical sensations such as fear or horror. 2). Deliberate avoidance of reminders likely to produce re-experiencing of the traumatic event(s). 3) Hypervigilance (although unlike PTSD, in CPTSD the startle response may be muted). In addition, for CPTSD: 1) Problems in affect regulation; 2) Beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event; and 3) Difficulties in sustaining relationships and in feeling close to others. Symptoms of CPTSD may vary according to culture and females are at greater risk than males.

Although complex trauma is often rooted in childhood maltreatment, ICD-11 does not have separate criteria for CPTSD in children. It does note children and adolescents are more vulnerable than adults to developing CPTSD and, where attachment figures are the source of trauma, children and adolescents often develop disorganised attachment.

The American Psychiatric Association (2013) added a sub type of PTSD for children under 6 years that is more developmentally sensitive and includes manifestation of trauma symptoms in play. Cruz et al. (2022) note this revision suggests PTSD in children may differ from that in adults and traumatised children are discernibly different to non-traumatised peers.

One problem with the CPTSD diagnosis is co-morbidity. Children under five may also be diagnosed with Reactive Attachment Disorder or Disinhibited Social Engagement Disorder, and children and adolescents with Depressive Disorders, Eating Disorders, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Conduct-Dissocial Disorder, and Separation Anxiety Disorder (World Health Organization, 2019).

Assessment of CPTSD and DTD in Children

An impressive amount of research went into validating the CPTSD diagnosis producing a number of clinically useful scales. For example, the self-report Trauma Symptom Inventory (Briere et al., 1995). There is also a scale for DTD (Spinazzola et al., 2021). See also the International Trauma Consortium[1].

The assessment of CPTSD and DTD in children and adolescents is dominated by questionnaires with little use made of structured interviews (e.g., The National Child Traumatic Stress Network,

2025). There are also a number of comprehensive trauma-focused clinical assessments such as the Chadwick Centre (2025).

An exception is the narrative story stem procedure (NSSP). This is a doll play technique in which an interviewer, not known to the child, presents the child with the start of a story (the stem) and, using a few simple props, asks the child to "tell me and show me what happens next". Kelly and Bailey (2012) estimate at least three dozen methodologies use this approach in hundreds of published studies. Various batteries of stories are available and there are around half a dozen systems of analysis, some coding for attachment (see Farnfield, 2014a on NSSPs and attachment). With a few exceptions quantitative analysis predominates over qualitative (see Kelly & Bailey, 2012 for review).

A major advantage of the NSSP is that, unlike questionnaires, it offers a direct window into the experience of an individual child (Emde et al., 2003) and so has been effective in the understanding and treatment of traumatised children (e.g., Hodges et al., 2003). A number of investigators have used the NSSP to screen for post traumatic play (e.g., D'Elia et al 2022, Farnfield & Onions, 2022; Løkkegaard et al., 2021). Given the objection that children's 'stories' and 'play' do not necessarily reflect the reality of their lived experience, construct validity of the NSSP (Kelly & Bailey, 2012) convergent validity across cultures (Wan et al., 2024) is encouraging.

Attachment

There is a consensus that DT has an adverse impact on child attachment. The two competing theories of attachment are the prototype ABC+D model and the Dynamic Maturational Model of Attachment and Adaptation (DMM). The former is grounded in the Ainsworth infant ABC patterns (Ainsworth et al., 1978) with the addition of disorganisation (D) (Main & Solomon, 1986), and is the one more widely used in research. The DMM is also based on Ainsworth's model but diverges from the ABC+D in that it does not use D but identifies expansions of A and C according to context and maturation (Crittenden, 2006).

The DMM is the model used here and significant differences and unresolved problems are as follows (for a full explanation of the DMM see Crittenden, 2016):

- Whereas ABC+D is largely rooted in infant behaviour, the DMM expansions offer a further twelve sub-patterns, A3-8 and C3-8 together with combinations of A and C.
- Using the Adult Attachment Interview (AAI) (Main & Goldwyn, 1984-1998) ABC+D codes for unresolved loss and trauma, mainly in a preoccupied form. Conversely, the DMM-AAI (Crittenden & Landini, 2011) has fourteen types of unresolved loss and trauma, rooted in dismissed and preoccupied with a similar range identifiable in DMM child and adolescent assessments (Crittenden et al., 2021).
- The ABC+D model sometimes assesses children from at risk populations as securely attached. A meta-analysis of the attachment patterns of institutionalised children found rates of security as high as 74% (Lionetti et al., 2015). This is a bizarre situation with no theoretical or empirical explanation. Likely these cases would be rated in the A3-8 sub-patterns using the DMM (see Farnfield, 2014b).
- The DMM codes for what are termed modifiers (see below). These refer to chronic disruptions of affect regulation and are the closest the DMM gets to D.

The Child Attachment and Play Assessment (CAPA)

Underpinning Ideas

The gold standard for attachment assessments is Ainsworth's strange situation procedure (SSP) (Ainsworth et al., 1978). Like the SSP, the CAPA assesses both attachment and play/exploration. The theoretical and empirical back ground is as follows:

- Winnicott's potential space (1971) and the development of mentalising in children (Fonagy et al., 2004)
- Constructs used in the MacArthur & Story Stem Assessment Profile (Hodges et al., 2003) and other Coding Systems (Emde et al., 2003)
- Play therapy with traumatised children
- Crittenden's DMM of attachment and adaptation
- The Infant CARE Index – assesses parent-child play (Crittenden & DiLalla, 1988).
- The SSP and Preschool Assessment of Attachment (PAA) (Crittenden, 2004) for observation of child behaviour when under stress
- Social engagement signals
- The AAI – how different patterns of speech can be used as an indicator of defensive exclusion (Bowlby, 1998/1980).
- Porges polyvagal theory (Porges, 2011).
- Sensory Attachment Intervention (SAI) (Bhreathnach, 2025a)

Procedure

Use of the NSSP is developmentally possible from 36 months; the age that approximates to the 'move to representation' (Main et al., 1985), when children are able to re-present to the self and an attentive adult internal representational models of attachment. Most systems do not employ the procedure beyond 7-8 years, but the CAPA has routinely been used with children up to the age of 12 and we are now developing a system for adolescents.

All attachment assessments need to generate moderate anxiety in subjects for attachment behaviour to be activated. In the NSSP the child's attachment system is activated by completing stories about attachment with a strange adult. Other than a warm up story, all the stories pull for attachment: for example a child/little animal gets lost or the child burns his/her hand. The CAPA uses a combination of the MacArthur (Bretherton & Oppenheim, 2003) and Anna Freud stories (Hodges et al., 2003) for pre-school children and has separate sets for school age children and adolescents.

Although the Anna Freud procedure has twelve stories, we have found they take too long and children get tired or bored. A CAPA procedure uses about seven stories and takes about twenty minutes for pre-schoolers and 30 – 40 minutes for older children. The CAPA is video recorded and coding by a reliable coder takes about two to three hours, depending on the complexity of the child's situation. Training and reliability take about 150 hours spread over six months (see Farnfield, 2025).

Coding Constructs

Coding is organised around the following seven constructs.

1. The child's relationship with the interviewer
2. The child's observed level of physiological arousal

3. Social engagement signals (body language)
4. Discourse, either verbal or in the play (telling or showing)
5. Mentalising
6. Markers & patterns for unresolved trauma and loss
7. Chronic problems with affect regulation – the DMM modifiers (see below).

Rather than counting the number of times a significant marker appears, in accordance with other DMM procedures, coding is a pattern recognition exercise. This means the coder is looking simultaneously for similar patterns across all seven constructs.

Validity

At the time of writing there are four peer reviewed published CAPA studies with an aggregate data base of 300 children (Farnfield, 2015; Farnfield & Onions, 2022; Wauthier et al., 2022, 2023). Data from a further 380 in four separate samples are currently under analysis. The CAPA has convergent validity with the CARE-Index (Crittenden & DiLalla,1988), an observational procedure for pre-schoolers, and an attachment interview for school age children (Farnfield, 2014b). Also construct validity regarding attachment insecurity and known risks in the environment such as parent mental health (Farnfield & Onions, 2022). It distinguishes between endangered (largely children in foster care) and safe community children (Farnfield, 2015), and community endangered children from severely maltreated children in residential care (Farnfield & Onions, 2022). Stability of attachment using the CAPA over a two-year period with a group of highly traumatised institutional children (here referred to as the MB study) was 70% (Farnfield & Onions, 2025). Finally, there is good correspondence between unresolved trauma on the CAPA and validated trauma scales (Wauthier et al., 2023).

The CAPA and Developmental Trauma

The CAPA is designed to inform treatment, not a forensic assessment to prove a child has been abused by a particular person. A CAPA coding is composed of three parts: the child's attachment strategy; unresolved loss and/or trauma and, third, chronic problems in affect regulation (the DMM modifiers). Attachment is determined by patterns across the first four constructs. Mentalising is a separate category useful for treatability but not discussed here. The last two constructs provide an estimation of the degree of traumatisation. Loss/trauma is determined by discourse and specific markers (construct 6) and affect regulation by construct 7. In terms of the ICD11 PTSD criteria for adults, the CAPA codes for pre-occupied trauma and hypervigilance. Deliberate avoidance (dismissed trauma) is, by definition, harder to detect; in particular the A+ attachment strategy is organised around psychological avoidance. With regard to ICD11 adult CPTSD, the CAPA screens for problems in affect regulation and the relationship with the interviewer. Shame and guilt typically form part of the mindset in A+ attachment.

Taken together the constructs form the basis for formulating a hypothesis concerning the impact of developmental trauma on a particular child. The three components are now explained in more detail.

Attachment

The DMM attachment patterns are given in figure 1.

Figure 1
DMM A+ and C+ Patterns

Type A+	Type C+
Idealise attachment figures	**Fight**
A3 role reversal	C3 aggressive
A5 indiscriminate attachment	C5 Punitive
A7 idealisation of dangerously abusive carers (Stockholm syndrome)	C7 menacing.
Negate the self	**Flight or cling**
A4 compulsive compliance with adult demands	C4 feigned helplessness
A6 compulsive self-reliance	C6 obsessed with rescue
A8 externally assembled self.	C8 paranoid.

The notation A+ or C+ refers to the DMM A3-8 and C3-8 sub-patterns to distinguish them from the normative insecure Ainsworth A1-2 and C1-2 patterns. At the risk of over simplification, the DMM strategies are organised in terms of how they deploy flight fight or freeze.

A+ is a self-defensive strategy that takes the perspective of abusive adults; hence the self is 'bad', the child blames the self for their predicament and tries to please or placate attachment figures and other powerful adults (Crittenden, 1992). Because Type A+ inhibits feelings of vulnerability it is a form of freezing peculiar to humans (see Porges, 2011). The odd A+ subscripts idealise attachment figures and the even numbers negate the self. Taken together they represent gradations of a false self.

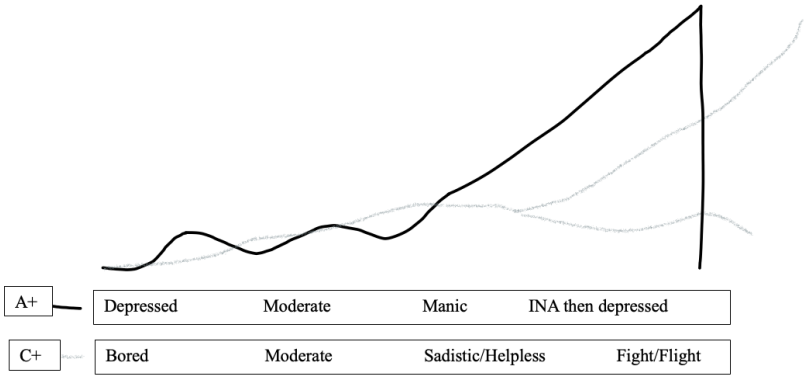
Type C+ uses combinations of fight alternated with flight or cling. In C3, aggression masks vulnerability and the desire for comfort. In C5, vulnerability of the self and others is dismissed meaning children using this pattern are capable of calculated acts of aggression or violence. On the even numbered side, C4 and C6 are forms of passive aggression in which anger is sugar coated with helplessness and obsession with rescue.

The strategic range of attachment behaviour increases with development. C3-4 and A3-4 are pre-school patterns and may be expand, with maturation, to C5-6 in the school years and A5-6 in adolescence. Types C7-8 and A7-8 develop in adulthood (Crittenden, 2006). CAPA coding follows the orthodox DMM model with the exception of A8. Imitation forms a key part in the development of pre-school children and the CAPA has coded for A8 in the schools years since its conception. A8 is predicted to develop from multiple home placements (Crittenden & Landini, 2011) and the MB study (Farnfield & Onion, 2025) is the first to provide empirical evidence.

In all cases it is the child's perception of safety and danger that motivates behaviour. For children who have never been safe, it is the deployment of their strategy that increases feelings of security rather than safety per se; one of the reasons DT is so hard to alleviate.

Following other DMM studies (Crittenden et al., 2021), the CAPA MB study assessed a miniscule percentage of abused children as B secure and all of these were reorganising to B from an A+ or C+ or A/C pattern. Likewise a tiny number of children were assessed in normative insecure A1-2 or C1-2 patterns.

Figure 2
The Arousal Cycle in A+ and C+



Comfort 'Disorders'

In A+ and C+ comfort (love, tenderness, safe caresses) has been denied or is otherwise unobtainable. Children in both patterns find it extremely hard to use even caring adults to help them coregulate their arousal but their reaction differs. Children using A+ feel they are responsible for managing their own affective states and so tolerate a world where they do not receive comfort. This inevitably leads to breakdowns of strategy – what the DMM calls intrusions of forbidden negative affect (inas). Adults have decided anger and desire for comfort are forbidden so when desire for comfort breaks through the child has an ina. These occur only in A+ and frequently take the form of rages, where, unlike C+, the child is out of their own control. They may also result in unregulated comfort seeking approaches that are seen by adults as 'inappropriate sexual behaviour'.

In C4, and particularly C6, elicitation of comfort is now used to the point the child may make her or himself vulnerable to further abuse. In C5 the primary source of comfort – mother – is trashed. This is particularly an issue for boys aged around 10 – 12 years. CAPAs of boys using C5 show alarming examples of misogyny, sexual sadism and denigration of motherhood

In Bion's terms, one of the functions of an attachment figure is to act as a container for their infants physiological and later affective arousal (Bion, 1962/1991). An important finding from CAPA studies is the arousal cycle in A+ differs significantly from that in C+ (see figure 2). In A+ the child feels responsible for managing their arousal and cannot use the interviewer or therapist for co-regulation. Watching the CAPA video we see the child's arousal run in a wave of troughs and peaks: often pulling themselves up to complete the story and slumping back down between stories. This can be quite stark: the child gets up and walks round the room, sits down again, cheerfully completes the story then lies on the table with their head on the hands or even kneels on the floor. When highly aroused the child appears manic or has an ina, for example sticking their tongue out at the camera. Inas and manic states of arousal frequently end with a slump back into depression.

In C+ the child does make use of the interviewer, however this is not the co-regulation seen in B secure, but forcing the interviewer to respond to intense displays of controlled aggression (C5) or self harm (C6). Interviewers often experiences a disturbing emotional counter transference including shock and revulsion (response to C5-7) or a desire to rescue (C6).

In both A+ and C+ the inter personal process by which this happens is best captured by Klein and Bion's description of projective identification (Klein, 1975; Bion 1962/1991). In A+ the interviewer/therapist may be listening or observing stories that clearly stem from maltreatment but s/he feels tired or bored as if the child is signalling, "there is nothing to see here, don't worry about me." In C+ the interviewer is forced to feel some of the split off feelings the child cannot contain her/himself.

Unresolved Loss and Trauma – Affect Regulation

While some children exposed to DT are able to organise around trauma using their attachment strategy, others show lapses in strategic functioning (DMM unresolved loss or trauma) and/or more chronic somatic problems (the DMM modifiers). In effect we are looking at a continuum, given in Figure 3.

Figure 3
Developmental Trauma – Mental and Somatic Representation R, DO, Dip, INAs and ESS are DMM Modifiers (XX).

Mental representation - Unresolved loss or trauma in the discourse – shown or told
Reorganisation [R]
Dynamic post traumatic play Stuck or toxic play Disorientation (DO) Confusion regarding whether the self or others are the source of memories.
Somatic representation – Written in the body
Depression (Dp) denotes futility regarding the effectiveness of attachment behaviour.
Intrusions of forbidden negative affect (INAs) (anger, desire for comfort) in a compulsive A+ pattern.
Expressed somatic signs (ESS) somatic signs, such as repeated scratching, coughing, of experiences that cannot, for whatever reason, be brought to conscious expression.

Mental representations of DT are, at least in part, conscious and can be communicated in spoken discourse or in play. The CAPA criteria for unresolved loss or trauma are given in Figure 4.

Following the AAI, transforming dysfluency in the story telling refers to points where the child is transforming or excluding information that, if brought to consciousness, would entail them to suffer; Bowlby's concept of defensive exclusion (Bowlby, 1998). Dissociation, hypervigilance and loss of sensory regulation clearly have somatic components.

Figure 4
Capa Criteria for Unresolved Trauma

Transforming dysfluency in the discourse (spoken or play)
Concerning themes across stories e.g. wet beds, people looking down at dead people
Preoccupied stories in Type A+ which are told with flat affect. In effect the stories are preoccupied with regard to content but dismissing regarding affect
Hypervigilance e.g. suddenly looking at the door, asking the interviewer if someone is coming in, starting at noises the interviewer cannot hear
Weird or bizarre content
Content that feels chillingly real (often told with flat affect)
Somatic expression of bodily pain, e.g. showing the site of previous injury
Sudden loss of sensory regulation, e.g. tripping due to loss of muscle tone
Dissociation e.g. zoning out; temporary loss of connection with the interviewer and/ or the task.
Inability to use the relationship with the interviewer for relief – stuck or toxic play compared to dynamic
post traumatic play (Gil, 2017)

Using Figure 3, reorganisation is the closest modifier to strategic functioning with little or no DT. Reorganising stories show traces of an insecure pattern with passages that also rate B secure. Reorganisation is a modifier because it not only denotes a change in strategy but also entails disruptions to old ways of thinking, feeling and behaviour, rather like the experiences people may go through in therapy.

The difference between toxic and dynamic post traumatic play was described by Gil (2017). In the latter the child plays out parts of traumatic scenes and is able to use the mind and presence of the interviewer (in the CAPA) or therapist to find meaning in the experience. In toxic play the child repeats traumatic experience without new meaning or relief and so effectively re-traumatising the self. Disorientation refers to confusion about the source of memories and information so the child flips from an A to C pattern and back again without either functioning strategically. DO is very rarely coded in the CAPA.

The ability to turn trauma into a narrative is a sign of healing the wound whereas, in somatic representation, trauma ceases to be a story one can tell and is written in the body (van der Kolk, 2015). Somatic, bodily trauma, veers from very low to manically high states of arousal. In the DMM depression is not a quasi-psychiatric diagnoses, although there are some overlaps: flat affect, sadness and futility regarding the effectiveness of attachment strategies. The discourse often has a striking clarity that invites a B secure coding but on inspection what the child sees so clearly is the impossibility of any change. Intrusions of forbidden anger or desire for comfort are described above. Expressed somatic signs are the physical manifestations of episodes that cannot be talked or even thought about (Bowlby, 1979). For example, at first it appears the child has a cold. She sniffs and scratches her lip; but as the stems progress her sniffing and scratching gets more and more pronounced, particularly at points she is anxious. The interviewer points this out to carers and other professionals who know the child well and they say, "Oh, she always does that."

Rethinking Psychiatric Diagnoses

Many children are referred to professional services for problems with affect regulation: Johnny cannot control himself; Johnny is defiant; Johnny is given a diagnosis such as ADHD, PDA, CD. There has been an explosion in such diagnoses and many children are put on medication. Far fewer children are referred because they are sad, depressed or so anxious to please they negate their own needs; in other words the children successfully using an A+ strategy.

From a DMM perspective a significant number of these diagnoses could be explained in terms of both strategic behaviour and breakdown in attachment strategy. DMM studies have found that psychiatric diagnoses rarely correlate with DMM attachment patterns (Crittenden et al., 2021). However, in the CAPA-MB study, at entry to residential care 81% of children with anxiety disorders were in the A+ group (p = <. 046, ∅.358) and 75% two years later (T2) (p = <. 044, ∅.395). The A+ strategy is poorly equipped to contain arousal when compared with Type C+. In A+ the self is responsible for affect regulation whereas Type C+ is intensely interpersonal with a focus on the self and its problems.

At T2, children assessed as unresolved regarding loss were significantly more likely to be diagnosed with depression, anxiety or attachment disorders and, crucially, to play out scenes depicting loss of family. This supports the reframing of attachment disorder using an attachment rather than medical model. For these children, 'attachment disorder' was their response to loss of family, whether birth or previous foster carers was not clear.

Of great significance for the validity of the model was the bi-directional relationship between the depression modifier and inas. Depression at entry correlated with inas two years later, and vice versa. This gives empirical evidence for the DMM seesaw of arousal in A+ described above. The display of one or other state (dp or ina) may change frequently and clinical diagnosis may be influenced by not just the day but the hour an assessment takes place.

Intervention and Therapy

The first requirement when trying to help DT children is to remove the source of danger. There is likely a consensus that before any therapeutic work can begin the child must be in a stable and safe environment. This is the responsibility of child protection agencies for whom the most radical intervention is removing the child to foster care. The problem is that separating children from their parents is in itself uniformly damaging (Crittenden & Spieker, 2023) and greater use needs to be made of schemes that try to ensure children are safe while simultaneously keeping them with parents or relatives (Crittenden et al., 2024). When children are still unsettled, for example in a short term foster placement, use can be made of 'bridging therapies' otherwise traumatised children can go for years with no therapeutic help. The usefulness of contact with an adult mind that tells them: "you are not made, it is the world that is mad and what you feel and do is normal behaviour under abnormal circumstances", should not be underestimated.

The clinical utility of the PTSD and CPTSD diagnoses "has yet to be investigated" and, because of its complexity, CPTSD may require a greater number of interventions and longer courses of treatment (Cloitre, 2020). Best practice guidelines for the treatment of CPTSD in adults are built around a three phase approach. Phase 1: ensure the person is safe; reduce symptoms and increase psycho-social competencies. Phase 2 Focus on unresolved aspects of traumatic memories and Phase 3 consolidation and facilitate transition to greater engagement with relationships and social life (Cloitre et al. 2011). A meta-analysis of treatment for adult CPTSD gave some support for Cognitive behavioural therapy (CBT), exposure alone

(EA) and eye movement desensitisation and reprocessing (EMDR) but noted few RCTs reported affect dysregulation data and outcomes were poorer for subjects traumatised as children (Karatzias et al., 2019).

Likewise, validated treatments for children and adolescents with DTD are limited. In his seminal work on DTD, van der Kolk notes, "Treatment must focus on three primary areas: establishing safety and competence, dealing with traumatic reenactments, and integration and master of the body and mind ... Unfortunately, all too often, medications take the place of helping children acquire the skills necessary to deal with and master their uncomfortable physical sensations." To "process" their traumatic experiences, these children first need to develop a safe space where they can "look at" their traumas without repeating them and making them real once again" (van der Kolk, 2005).

Integrative and relational treatments may be effective (Cruz et al., 2022) but evidence for efficacy varies. For example, the Attachment, Regulation and Competency (ARC) model has a number of peer reviewed papers (see ARC[2]) whereas empirical support for Hughes' Dyadic Developmental Psychotherapy, widely used with families with fostered and adopted children in the USA and UK, appears to be thin (Hughes, 2017). Sachser et al. (2017) used 12 sessions of Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) with children and adolescents diagnosed with either PTSD or CPTSD. The programme included psycho-education, relaxation and affect regulation. Both groups responded to TF-CBT but the CPTSD group ended treatment with clinically and statistically greater symptoms than those with PTSD.

DMM Functional Formulation

There is no DMM therapy. Crittenden has long taken the view that we have enough therapeutic modalities to be going on with and the purpose of an attachment assessment, like the CAPA, is to assist in the selection of the therapy most likely to succeed with a particular child. To this end, DMM practitioners and therapists have focussed on formulation, with particular attention to the whole family system (Dallos et al., 2019), to arrive at a DMM informed integrative treatment (Crittenden et al., 2021). Unlike a diagnosis, a family functional formulation (FFF) is a hypothesis open to review and change during treatment (Landini, 2014).

Rather than looking at symptoms or behaviour, DMM assessments focus on information processing (in mind and body). Using a CAPA assessment, intervention could be planned using the following steps These are no more than suggestions until empirical evidence for their effectiveness becomes available:

Affect regulation Where trauma is written in the body (any one of Dp, INAs, ESS or hypervigilance) this should be treated first using a somatic intervention aimed at helping the child co-regulate their arousal, ideally with attachment figures. With are currently co-evaluating Breathnach's Just Right State Programme (Bhreathnach, 2025b). Clinical experience indicates dance and music therapy may prove effective.

Unresolved loss and trauma Where trauma is at a representational level a wide range of psychotherapies that use spoken language and/or symbolic communication should be useful. Gil gives useful pointers to changes in therapeutic technique for dynamic post traumatic play and for toxic play (Gil, 2017). DT does not get better on its own and what seems essential is that the therapy makes explicit reference to the child's lived experience. Children's CAPA stories frequently contain episodes and fragments of episodes based on reality together with themes across stories and these can be very useful in treatment. Occasionally children will make a disclosure of abuse, during or after the CAPA, that necessitates a child protection enquiry.

Attachment strategy Attachment strategies are just that – strategic. Attempting to change a child's self-protective strategy without first eliminating the dangers it is responding to can cause actual harm. Changing attachment is anyway hard, and likely hardest during developmental 'latency' in the school years. In the MB study the main change over two years was from A+ to A/C as children adapted to a mode complex environment; they were in residential care but still had contact with foster or birth families. If the CAPA and clinical history indicate the child is suffers no major traumatic disturbance then attempting to treat their attachment strategy alone may be unnecessary. That said the following observations may prove helpful.

Type C+ is much more resistant to change than A+ (Farnfield & Onions, 2025) and there are many pitfalls awaiting the therapist working with children and young people who use this pattern. First there is a risk of collusion. The C+ patterns split cognitive and affective information, and people, into positive and negative. When the therapist challenges the negative the child will react, and the therapist may be tempted to back down and conform with the child's world view. Children, and adults, using C+ have endless episodes to delight their therapists, many depicting the self as victim. While some of it is true, the C+ mindset is to use victim hood to justify attacks on, or elicit rescue from, other people. Children using C5/7 mistrust adults and see danger in genuine overtures of comfort. As with adult Borderline Personality Disorder patients, a secure base approach, common to most therapies, may actually make the child more anxious and suspicious (Bateman & Fonagy, 2006). Somehow the therapist has to gain the trust of the child and then try and help the child achieve empathy with others. This is no mean task. The good news is that people using a C strategy are intensely interested in relationships.

The A+ pattern is cognitive so CBT is likely the wrong therapy for this pattern; certainly attending to cause and effect (something the child using A+ is good at) may only increase their already strong sense of self blame. Any therapeutic modality that enables the child to find a true self is recommended for trial. The trap for the therapist is that the child is eager to please and may borrow the therapist's perspective to wear as another layer of a false self. Experience indicates the A8 pattern is responsive to non-directive play therapy.

The following brief case study illustrates how the CAPA can be used in formulation. An extensive child abuse case study is by Crittenden and Poggioli (2011).

We will call this boy Harry. He is 10 years old. Because any history or background information can bias coding, all the coder knew was Harry's age and that he was male; for DMM Good Practice see Crittenden et al. (2013).

Here is an abbreviated summary of Harry's CAPA coding.

Relationship with Interviewer

Harry finds the procedure hard. He is genuinely struggling (A+) not refusing, as in C+. He doesn't want to do the stories but he does the best he can; a sign of compliant A+. In repose he is sad.

Arousal

His arousal drops steadily as the exercise goes on. He does not show the up and down wave of a regulated A+ strategy so this suggests depression.

Social Engagement Signals

A lovely smile to his brother who is in the waiting room and a few laughs with the interviewer, but at crucial points Harry makes no eye contact and is emotionally flat when talking about positive things – e.g. the reunion with parents. At one point he smiles when describing how the father doll hits the child – false positive affect (A+).

Discourse

A4 with one example of A5.

Mentalising

The accuracy of depression – Harry can name intense feeling states like "scared" but can produce nothing in his stories to alleviate them.

Trauma

A running theme of loss of family. Is Harry in foster care? At this point we do not know. There is one scene where the father repeatedly hits the child. This has elements of stuck play.

Modifiers – Affect Regulation

Depression; flat affect, and his stories end in futility. At the start Harry makes a two fingered V sign at the camera when the interviewer is not looking – an ina.

ESS – sniffing that gets more pronounced as the procedure unfolds.

Coding: Depression, Unresolved loss of his family, possibly Unresolved trauma physical abuse, A4 INA (anger) ESS sniffing

Note that the possibility of physical abuse does not mean the CAPA can be used in evidence against Harry's father. As noted above, this is not a forensic assessment procedure.

The coder then had a meeting with the referrer's: Harry's social worker and psychologist. Harry is the youngest of five children. His parents were together but have now separated. There is a long history of alcohol abuse and domestic violence. Harry recently went to school with bruises on his back and pinch marks on his arms but would not say who did this to him. The child protection authority have referred the family to a specialist Family Drug and Alcohol Court. Harry is in foster care with one of his brothers.

Ideally Harry and his family might benefit from:

- Direct therapy to try and help him shift the trauma (INA ESS) from his body to a more conscious position where by he can share it with the therapist. Trauma needs to be dealt with directly and explicitly.
- In parallel, work with his parents on their relationship, parenting and needs of their children followed by parent-child intervention such as filial therapy (van Fleet, 2005) Theraplay (Booth & Jernberg, 2010).

Unfortunately the prognosis for rehabilitation is not good. Harry's mother has been diagnosed with depression and is living with her mother. A DMM-AAI with his father indicates his mentalising is low and his pattern is C7. Father has a history of 'false imprisonment' (locking previous female partners in his cellar) and Harry's mother says he strangled her to point she wet herself.

Harry has "a long history of challenging behaviour" and is now excluded from school. The psychologist assessed him for ADHD but did not think Harry met the criteria. Looking at his CAPA and the family history, Harry is suffering from DT locked in his body with somatic expression and outbursts of rage he cannot control. Harry really would like to be liked and to conform to the rules (he uses A+) but his body won't let him and his mind is so full of horrible things he can't think straight.

The professional team discussed setting up a compensatory relationships for Harry starting with play therapy; this was not the first therapy of choice in an ideal world but the easiest to access. They then put together the following programme:

- Psycho education – a short course teaching Harry how fear without relief produces sensations in his body and sometimes his mind.
- SAI informed intervention with Harry and his foster father (Bhreathnach, 2025a), with whom he was developing a positive relationship, to help Harry manage states of unbearably high or low arousal.
- Psycho-therapy aimed at his specific experience of trauma.

After eight months work Harry was better able to regulate his feelings and to talk about physical abuse from his father whom he still idealised. Neither of his parents would engage with therapeutic work and his social worker was working towards Harry living with his maternal grandmother and mother. There are tens of thousands of children like Harry in every country.

Conclusion

The CAPA can be used where clinical history and screening, using a questionnaires, indicate a more in depth assessment of developmental trauma may be useful. Of the available systems for analysing the NSSP, it, arguably, provides the most comprehensive portrait of an individual child in terms of attachment, representational and somatic forms of trauma. In all cases a full clinical assessment including then history of care and parent-child observation is essential.

Although it has been used in clinical practice for several decades the empirical base for the CAPA is still modest. Research by practitioners to evaluate the effectiveness of different therapies is crucial. An important next step is the see if observed states of physiologically arousal are accurate. For that we need studies using bio-physiological measures such as skin conductance and heart rate variability.

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Conflict of Interest

The author of this manuscript declares that there are no financial, personal, academic, or institutional conflicts of interest that could have influenced the conduct of this study, the data analysis, or the interpretation of the results.

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